School Cafeteria Employees UNITE/HERE Local No. 634
Health & Welfare Fund

911 Ridgebrook Road
Sparks, Maryland 21152-9451
(833) 228-9212
www.associated-admin.com

ENROLLMENT FORM
(For Cafeteria Workers)

Name of Employee

Last Name	First Name	Middle Initial	OFFICE USE ONLY	
			Effective	Terminated
Street Address			A.	
			B.	
City	State	Zip Code	C.	

Telephone	Sex: M ☐ F ☐	Date Employed	Date of Birth

Your Social Security No.

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

DEPENDENTS – SPOUSE AND CHILDREN UP TO AGE 26 (FOR VISION, DENTAL & RX COVERAGE ONLY)
You must provide a copy of a Marriage Certificate for spouse and a Birth Certificate for each child to confirm Dependent Eligibility.

LIST NAME IN ORDER OF AGE – ELDEST FIRST FIRST NAME MI LAST NAME	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER

If you have a change to family status or address change, you must complete a new Enrollment Form. Please call the Health & Welfare Fund Office at (833) 228-9212 to request an Enrollment Form. Mail complete Enrollment Form to the address at the top of this form.

DECLARATION (You Must Sign and Date the Enrollment Form)
By signing this form, I represent that the information provided herein is accurate and complete. I agree to reimburse the Health & Welfare Fund the cost of benefits paid by the Fund as a result of any false information provided herein.

Employee's Signature (DO NOT PRINT): ____ Date: ______________